

ONE CHANCE TO GET IT RIGHT: EXPLORING PERSPECTIVES ON DECISION-MAKING FOR DISCHARGE TO CARE HOME

Research Team:

**Ms Gemma Logan, Dr Sarah Rhynas, Dr Jenni Burton,
Ms Azucena Garcia Garrido, Dr Juliet MacArthur**

In Collaboration with:

**Dr Susan Shenkin, Professor Alasdair MacLulich,
Professor Brendan McCormack**

**RCN International
Nursing Research Conference**

Thursday 5th September 2019



CONTEXT



The Scottish
Government
Riaghaltas na h-Alba

Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 201

Core Suite of Integration Indicators

21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home

National Health and Wellbeing Outcome:

People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Rationale for Indicator

This indicator represents the fact that the policy direction is to reduce the occurrence of people being placed directly into care homes from hospital without due consideration being given to more appropriate alternatives that suit the needs of individuals.

THE 'GIBSON TRUST' PROJECT

AIMS:

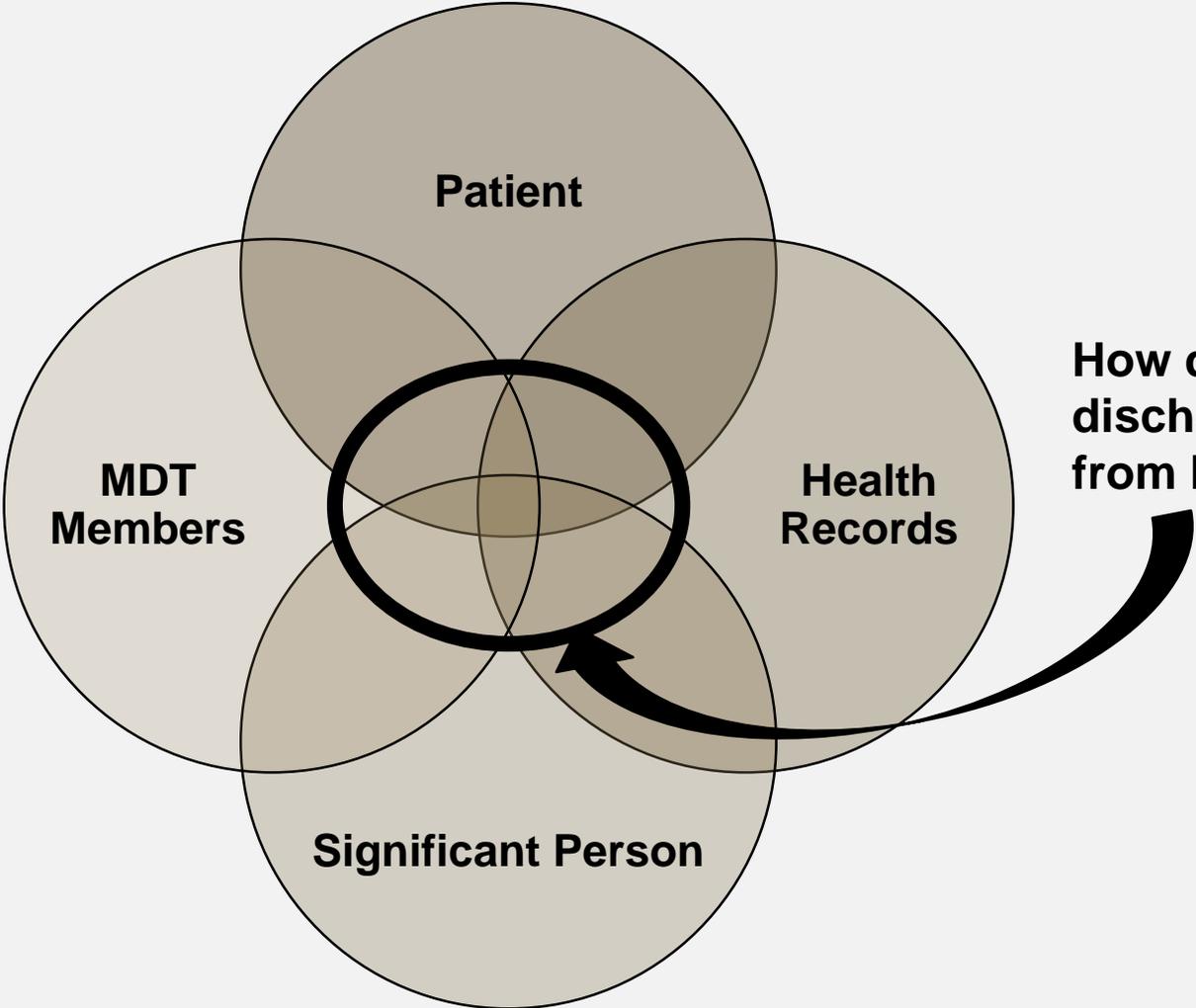
- Examine the decision-making processes involved in discharge to a care home
- To establish the role of undiagnosed dementia, cognitive impairment and delirium in these processes
- Funded by Alex and Elizabeth Gibson Trust
- Study period: **Admitted November 2013 – February 2015**
- Data extraction: April 2015 – September 2015

METHODS:

- Retrospective cohort study, n=100, consecutive cases sought
- Individuals admitted to one acute hospital and **newly admitted to a care home** at time of discharge
 - No comparison group of people discharged home
- Case-note review
- Data extraction by single researcher
- Quantitative & qualitative measures to inform:
 - Descriptive analyses
 - 10 detailed case-studies

ONE CHANCE TO GET IT RIGHT: EXPLORING PERSPECTIVES AND EXPERIENCES IN CARE HOME DISCHARGE DECISION-MAKING

Case study research:
uses a range of data sources to explore phenomena from different perspectives



How decisions are made to discharge patients directly from hospital to care home

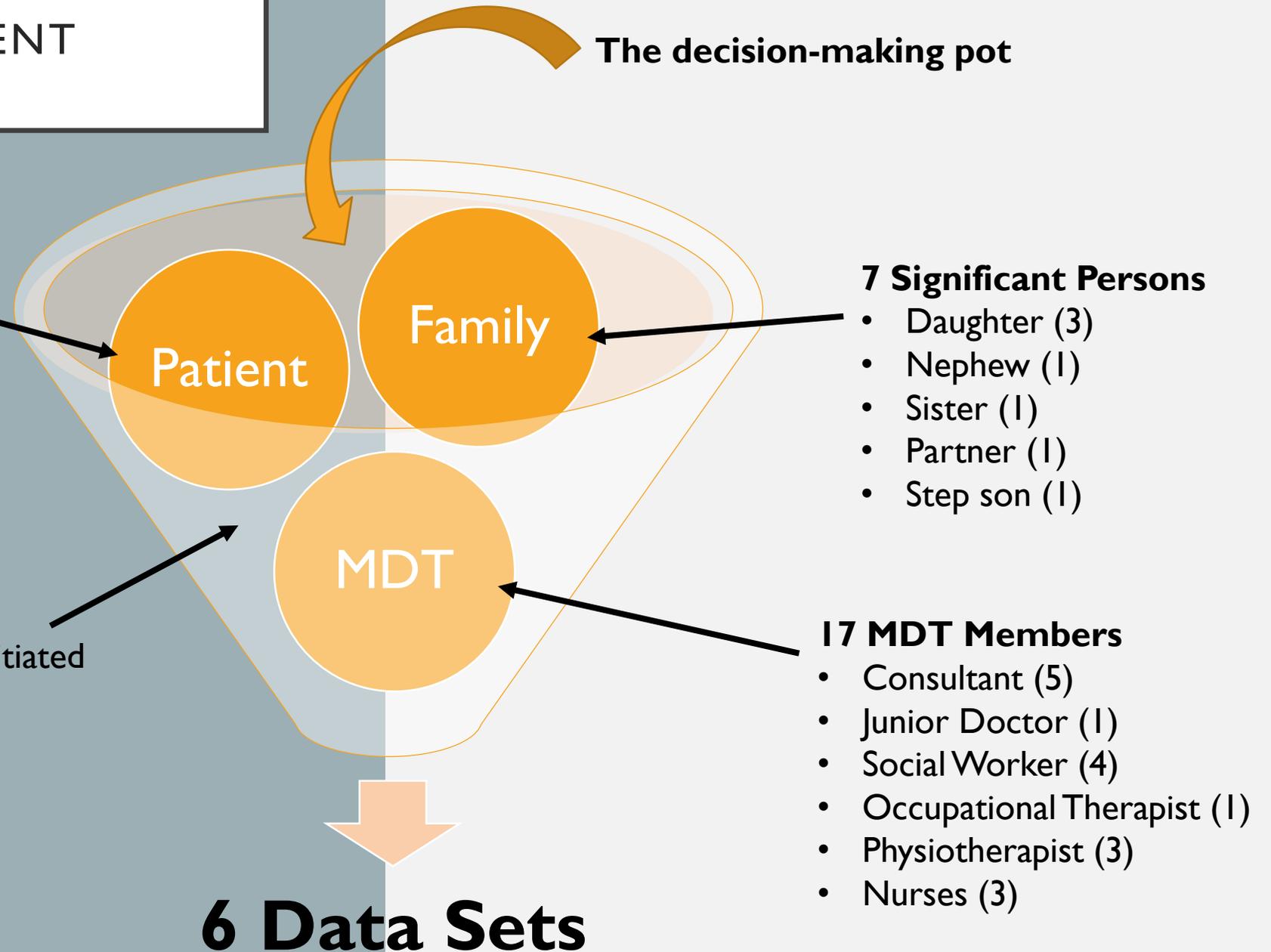
RECRUITMENT

6 Adult Patients

- From two acute hospitals
- Variation between sudden decline in function (e.g. through stroke) and gradual decline

Variation in who initiated the decision

- Patient
- Family
- MDT



Patient

Family

MDT

FINDINGS: ROLES

A Perceived Burden:

Isa: *“See, I’m not wanting to upset my daughter, she’s been a good daughter.....I was thinking of my daughter, the trouble that I was going to give her trying to look after me....And that’s what made me say well, the best place is...a nursing home.”*

Arthur: *“Just to be safe, be safe and no be a trouble to my family...”*

Peter: *“Mainly because the family were worried about me and I didn’t want that.”*

FINDINGS: ROLES

The Significant Person's Expectations:

Peter's daughter: "We just felt he wouldn't manage at home and we would just be worrying about him all the time."

Isa's daughter: "She stays in [place name] which is an hour and a half from us.....Which is fine.....we've been doing it for years.....But if in an emergency, it's not really been advisable and it, you know, it's no good to my mum really. I can't just say, 'Right, Mum, I'll be there in five minutes'."

FINDINGS: ROLES

Professional Expectations:

Agnes' Consultant: "I think it would have needed probably an increase in her already substantial package of care.....and I think with the support of her family that would have been feasible."

Arthur's Physiotherapist: "if the circumstances would have been different and his sister would have been heavily involved and readily involved, then no, we could have supported him at home. But he just lacked the support...."

FINDINGS: ROLES

Professional Division in Roles and Responsibilities:

Agnes' Consultant: *“You’re trying to guide people through decisions where you don’t really have all the information....”*

Agnes' OT: *“It’s definitely not my area of expertise and we don’t like to say anything that maybe wrong.”*

Peter's Nurse: *“We’re making sort of promises and plans when we haven’t got the expertise.”*

Harry's Consultant *“I don’t feel confident enough, I don’t know the details and I don’t think it’s.....necessarily my role to delve in to those details with them.”*

Time and space

Harry's consultant: *"there's always pressure to move people on, but there was no pressure for him. I didn't feel any pressure in making the decision...."*

Limits preferences

Agnes: *"I told him that I would like to go to [care home name]. Nowhere else but [care home name], because it's near hand and everything..."*

Makes difficulties
'public'

FINDINGS: THE CONTEXT OF THE DECISION

Significant point
in the journey

Permits conversations

A temporary arrangement

Socially acceptable discussion

Robert's social worker: *"when I spoke to him....I was thinking 'he thinks it's only going to be for a short time'. And again, the way I would play it is that we do our review after 12 weeks. So when I go back, if he expects to go back home, then we have that conversation at that point."*

FINDINGS: COMMUNICATION

People want to discuss the decision!

Peter: *“The staff haven’t bothered very much really [about talking about the decision]....”*

Arthur: *“Probably, could have, well, a meeting like this would be handy.”*

Harry’s nephew: *“.....what could have made it helpful, better? Simply brief discussions like this, a brief meeting so that [Harry] was very clear about what the next steps were.”*

Discharge to care home:

Complex process - needs careful consideration by staff.

Need for enhanced knowledge around discharge to care home process

Emotional and psychological support, effective communication

IMPLICATIONS FOR MULTI-DISCIPLINARY PRACTICE

Honesty and transparency

Shared professional responsibility

Person-centred discharge to care home

NEXT STEPS

Quality Improvement Project:

- Aims to improve communication with patients/families when considering care home

PhD:

- A critical analysis of discharge practices and how they help or hinder effective person-centred discharge of older people from the acute hospital setting.

Future Research:

- Must involve adults who lack capacity
- Following the transition to care home from hospital
- Last chance (home)?